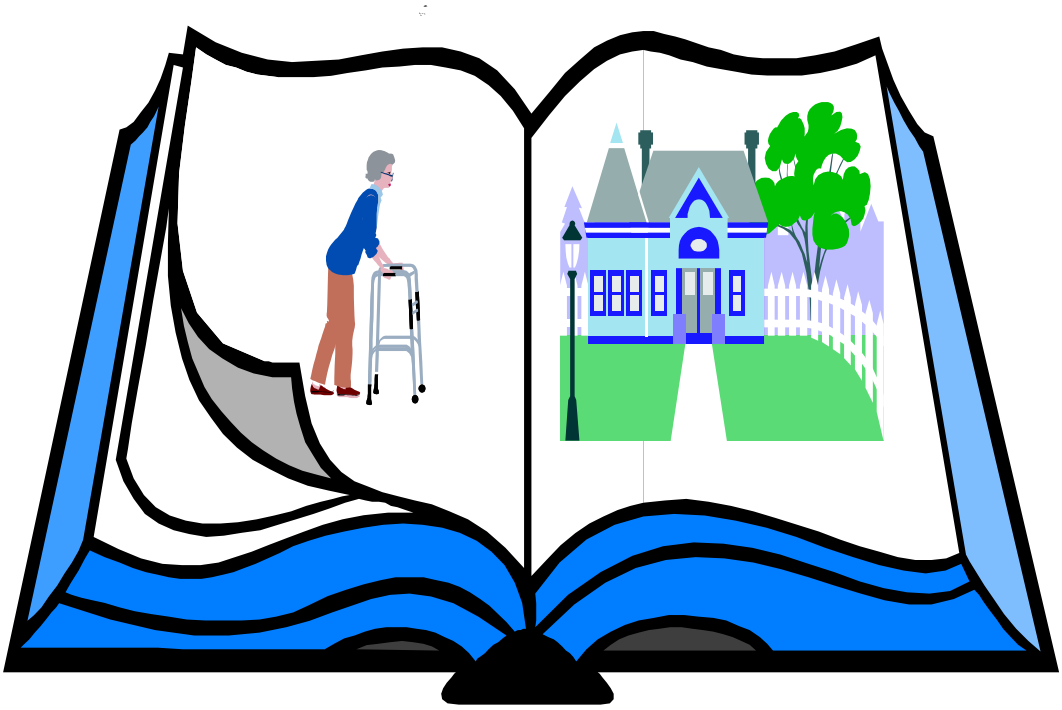
Arizona's Community Based Services and Settings Report

October, 2000



Published by:
The Arizona Health Care Cost Containment System
www.ahcccs.state.az.us
and The Arizona Department of Economic Security
www.de.state.az.us

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Report Summary

What is the Community Based Report?

The Community Based Services and Settings Report is a project to forecast and plan for the needs of the elderly and physically disabled (EPD) needing long-term care services in Arizona. This report shares data, trends, and findings from the two major long-term care home and community based programs managed by the Department of Economic Security (ADES) and Arizona Health Care Cost Containment System (AHCCCS). The ADES program is called Non-Medical Home and Community Based Services (NMHCBS). The AHCCCS program is called Arizona Long-Term Care System (ALTCS).

The concept, research, and drafting of this report was a collaborative effort of the community based project task force (see Appendix E). The members of the task force represent different regions of the state and include government and advocacy entities.

Goals and Objectives

The goal of the task force is to produce a bi-annual report that will be used by the task force and other entities to plan and forecast the needs of long-term care customers in the area of NMHCBS and the Medicaid Home and Community Based Services (HCBS) programs. The objectives of the task force in creating this report are to:

- Provide administrative and demographic data;
- Identify implications based on the data; and
- Share data and implications with other interested parties planning for growth.

Note: *Bi-annual rotation will begin in Fiscal Year 2001 to coincide with the state budget cycle.*

Background

> "If Arizona is going to meet the challenges and maximize the opportunities that the growth in our senior population is going to present, we need to seriously evaluate and start to plan for the health, housing, transportation, economic stability and many other needs that such growth brings."[1]

As the persons with disabilities and the aging populations grow in Arizona, the demand for NMHCBS and ALTCS will increase. Some of the demographic realities facing Arizona now and in the future are:

- In 1996, there were approximately 4.5 million people living in Arizona;[2]
- This is anticipated to increase to 9.8 million people in Arizona by 2040;[3]
- The number of persons 55 or older will increase from about 900,000 in 1995 to more than 2.1 million by 2020;
- By 2014, the number of persons 85 or older will double to approximately 149,000 and comprise 14% of the population aged 65 or older;

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[1] 72nd Arizona Town Hall and University of Arizona (1998). "Meeting the Challenges and Opportunities of Arizona' s Growing Senior Population,"pp. 1-3, Tucson, Arizona.
[2] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ
[3] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ

Background, Continued

- Currently 110,000 non-institutionalized Arizonans age 65 or older need some type of assistance with mobility or self-care;
- In 1989, the median income for a single male 65 years of age or older was $13,210 versus single women who were at $10,320;
- Arizona Native Americans account for 17% of the Native American population in the United States aged 65 or older;[4] and
- The ALTCS budget is approximately 30% of the total AHCCCS budget for 4% of the population.

In addition to the escalating growth for long-term care research needs, there is a national push by the disability community (elderly and physically disabled) for more input into their care. This is called "consumer directed care" or "person centered planning." This is further supported by the numerous articles that articulate the fact that the "baby boomers" will want more involvement in their current and future needs.[5]

Arizona must pay attention to upcoming issues regarding baby boomers. "The most significant is the fact that the baby bust generation (generation following the baby boomers) constitutes a much smaller proportion of the population than the baby boomers. As a result, there will be fewer working-aged adults to support the needs of a large elderly population through their economic productivity and tax revenues."[6] There is an increasing prevalence of caregivers in the workforce, thus increasing the need for outside services.[7]

This is even more important in a state like Arizona where the HCBS programs show an overall sustained growth. NMHCBS had a 14% overall growth in the last four years and the ALTCS population had an overall growth of 21% with an 8% population growth in HCBS. With the growth, comes an increase in expenditures. NMHCBS expenditures have grown by 9%. ALTCS/HCBS expenditures have increase by 40%. The good news however, is that for the ALTCS program, the state is listening to the consumers and increasing the percentage of persons living in the community. This is also a cost effective way to manage the long-term care program. Meanwhile, the capitation has remained almost constant from 1996 to 1999. This is because it is cost effective to have consumers live in their own homes or in alternative residential settings.

About the Report

The report is divided into four chapters:

- Who do we Serve?
- What are the Trends in Enrollment?
- Where Does Program Funding Come From?
- How is the Money Spent?

Continued on next page

[4] 72nd Arizona Town Hall and University of Arizona (1998). Arizona Department of Economic Security Projects, Tucson, Arizona.
[5] Accountability Action – Volume 4: Issues 1 and 2 (fall, 1999 / winter, 2000). "The Need is Real, the Time is Right," published by the Foundation for Accountability, Portland, Oregon.
[6] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.
[7] Aging Initiative: Project 2030 (December, 1998). "Final Report," p. 47, St. Paul, Minnesota.

About the Report, Continued

The report is primarily limited to information dealing with Arizona' s NMHCBS program and the ALTCS Program for SFY and FFY 1999. Other limitations include:

- NMHCBS utilizes the state fiscal year (SFY) calendar for annual reporting (7/1-6/30);
- ALTCS utilizes the federal fiscal year (FFY) calendar for annual reporting (10/1-9/30); and
- NMHCBS and ALTCS use similar data collection methodologies, but parameters may differ (e.g. age ranges).

The task force opted to focus on the EPD ALTCS and NMHCBS population. For more detailed information, including national comparisons, the reader may wish to review the 1998 Community Based Services and Settings Report presented by the community based project task force located on the Internet at http://www.ahcccs.state.az.us/Publications/reports.htm.

Policy Directions

Now is the time to increase our understanding of the economic trends and their intersection with demographics. Future growth and increased demands on the current structure require creative and innovative strategies from the community, for profit, non-profit and governmental agencies. Some findings that may have an impact on Arizona' s policy directions are highlighted below.

- Shifts in attitudes about the roles and responsibilities for formal providers of care;
- Aging population expected to reach 9.8 million people in Arizona over the next forty years;
- Changes in the roles carried out by the informal family support system;
- Cost and mandates of NMHCBS;
- Access, availability, and increased delivery of quality NMHCBS and ALTCS HCBS; and
- Maintaining a sufficient labor force to address the demand for services.

Conclusion

Nationally, both President Clinton and the United States Department of Health and Human Services (HHS) Secretary, Donna Shalala, have expressed their commitment to expanding access to home and community-based services for persons of all ages with disabilities. They stated, "We are eager to continue to work with states to help more individuals become aware of services and supports available to them in the community, and transition out of nursing homes if that is their choice."[8] Arizona needs to take advantage of this momentum and act on its policy directions with input from current and future consumers.

For two years, the community based taskforce has identified and discussed the need to share data and work collaboratively to forecast and plan LTC HCBS services. The goal of sharing data and implications has been accomplished by producing this report. The next steps for the taskforce call for maintaining momentum by continuing to:

- Share data;
- Identify gaps, forecast and plan for the future needs of LTC accordingly;
- Collaborate on key policy implications (e.g., additional needs and service gaps); and
- Monitor the progress of the efforts.

Both ADES and AHCCCS are committed to maintaining a range of services and supports for EPD Arizonans that seek to provide the population with choices in the maintenance of independence and dignity, while also addressing the needs of their caregivers.

[88] Health and Human Services (HHS) letter dated May, 2000.

Chapter 1: Who do we Serve?

Introduction

Currently, there are at least 265 million people living in the United States.[9] In 1996, there were approximately 4.5 million people living in Arizona.[10] This is anticipated to increase to 9.8 million people in Arizona by 2040.[11]

"In Arizona, the Department of Economic Security projects that the number of citizens 55 or older will increase from about 900,000 in 1995 to more than 2.1 million by 2020. By 2014, the number of persons 85 or older will double to approximately 149,000 and comprise 14% of the age 65 or older population. Currently, 110,000 non-institutionalized Arizonans age 65 or older need some type of assistance with mobility or self-care. [12] The information that follows describes the characteristics of individuals we serve in both Arizona HCBS program populations.

Fast Facts

NMHCBS and ALTCS populations demonstrate similarities in both gender and ethnicity. Both programs serve mainly women, 66 and 67% respectively. The primary consumer in the NMHCBS program is a white female between the ages of 75 and 89. In the ALTCS program, the primary customer is a white female between the ages of 80 and 89. They also serve similar ethnic populations.

The two programs have key differences in the age populations they serve. ALTCS serves a larger percentage of younger individuals as well as a larger percentage of very old individuals as compared to NMHCBS. The following statistics provide verification.

Program	Age Group	Percentage
ALTCS (EPD Only)	0 to 64*	24%
	90 and older	18%
NMHCBS	0 to 60**	10%
	90 and older	10%

* ALTCS Physically disabled (non-DD) children aged 0 to 21 have grown steadily since 1993. Examples of children within the program are: Ventilator dependent; Muscular disorders; Spina Bifida; and Behavioral health disorders organic in nature.

** By design, the NMHCBS program serves under 60 with a documented disability.

A typical in-home consumer will be a white female in her 80s who has sufficient activity of daily living (ADL) deficits such as bathing and instrumental activity of daily living (IADL) deficits such as shopping, laundry, and housekeeping to warrant assistance. Deficits are due to the aging and disease processes. Anecdotally, the NMHCBS program may keep consumers from entering into the ALTCS program by quickly providing services that help them maximize their independence at an earlier stage in the need for assistance.

Usually those consumers in the ALTCS program have more functional and medical needs. There are however, consumers in the NMHCBS program who are very frail but do not qualify for ALTCS because of income.

Note: *Future reports will track and compare demographic changes in the populations.*

Continued on next page

[9] AARP, (1998). Across the States 1998; Profiles of Long-Term Care Systems, pg. 5, Washington, D.C.
[10] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ
[11] AZ Department of Economic Security, Research Administration, Population Statistics Unit (1996 and 1997), Phoenix, AZ
[12] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

Implications

With the trended growth of the Arizona population as stated in the introduction, both programs can expect a steadily increasing aging and disabled population.

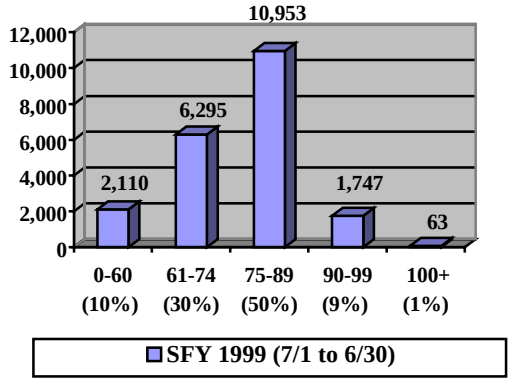
This may be compounded by the fact that there is an increasing prevalence of caregivers in the workforce, thereby decreasing the caregiver pool that has traditionally stayed at home. "The most typical employed caregiver, according to the U. S. Department of Labor, is a woman in her mid-forties who is employed and provides, on average 18 hours of care per week for her mother who either lives with her or nearby."[13] "According to a survey by the National Family Caregivers Association in Kensington, Maryland, 61% of those who have been caregivers for an extended period of time report feeling depressed, and 67% report being frustrated."[14] Two issues may then occur:

- The working caregivers need respite and request it from the HCBS programs (see growth in the respite program in the enrollment chapter); and/or
- The consumer may need more care than can be provided by the caregiver and requests it from the HCBS programs.

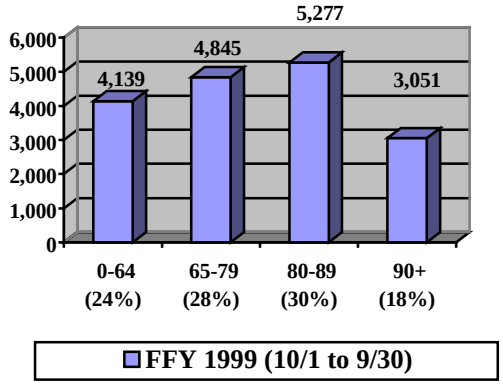
Age

The following charts show the differences and similarities between age cohorts, for both gender and ethnicity in NMHCBS and ALTCS.

NMHCBS



ALTCS (Nursing Facilities and HCBS)



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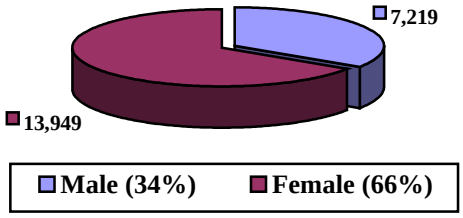
[13] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.
[14] Gauzer, Bernard (July, 2000). "How Can We Help," p. 4 and 5, Parade, Arizona Daily Star, New York, Now York.

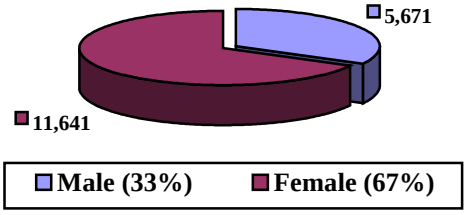
Gender

Both programs serve primarily women (65% NMHCBS and 67% ALTCS). ALTCS served 43% of its population in the community in FFY 1999.

NMHCBS (EPD population: 21,168)

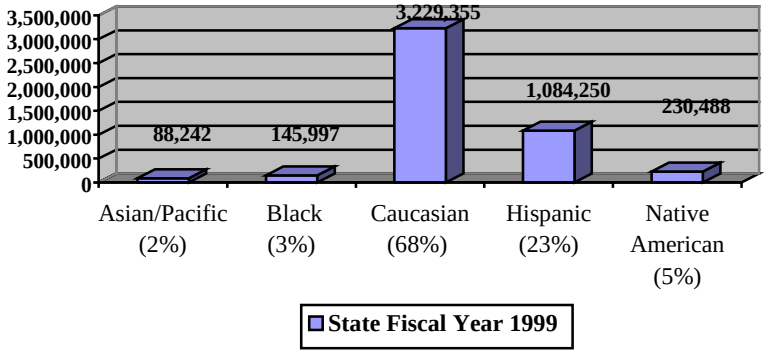


ALTCS (EPD population: 17,312)
(HCBS and Nursing Facility)



Arizona's General Population

A graph of the general population for Arizona has been included to compare the ethnicity of the general population to those in both programs. July 1, 1999 Arizona population estimate.

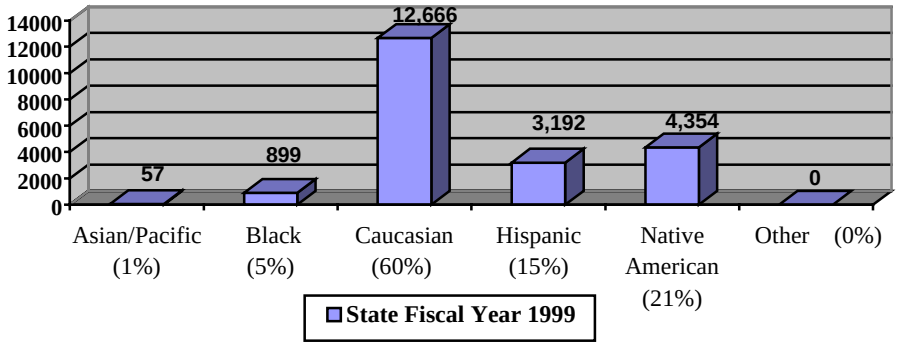


Source: *Population Estimates Program, Population Division, U.S. Census Bureau.*

Ethnicity

Both programs serve similar ethnic populations.

NMHCBS



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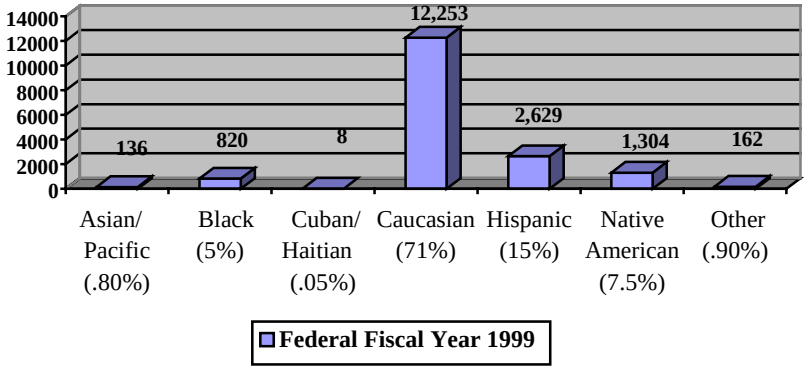
ALTCS (Nursing Facilities and HCBS)



Chapter 2: What are the Trends in Enrollment?

Introduction

"If Arizona is going to meet the challenges and maximize the opportunities that the growth in our senior population is going to present, we need to seriously evaluate and start to plan for the health, housing, transportation, economic stability, and many other needs that such growth brings."[15] Demographics coupled with the following information, when trended over time, may assist policy makers and stakeholders with future strategies in servicing this growing population.

Fast Facts

NMHCBS and ALTCS have seen an increase in demand for services as a result of growth in both programs. NMHCBS enrollment has grown 14% since 1996 (18,227 to 21,168). Service needs in NMHCBS changed from 1996 to 1999 (see Attachment C and page 5 for more details):

- Home health aid decreased by 26% as personal care increased by the same percentage;
- Home nursing has decreased in the same timeframe by 10%; and
- Respite has increased during this timeframe by 73% (Pent-up demand due to minimal funding prior to FFY 1997).

ALTCS HCBS population has grown from 35% to 43% of the overall EPD ALTCS population since 1996. Overall program growth for the last four years was 21% (12,788 to 16,187). The Joint Legislative Budget Committee (JLBC) has forecasted a 7% overall program growth:

- Nursing home enrollment has decreased by 4% of the total population since 1997 (1997=54% to 1999=50%); and
- With the advent of increased choice in settings, the number and percent of ALTCS members choosing alternative residential settings has increased significantly.

Implications

- The funding for the NMHCBS program has not grown proportionately to the expansion of this program' s consumer growth.
- The NMHCBS program operates on a fixed cost basis as it is not an entitlement. Due to this fact, the program has been unable to fully meet demands of those requesting and qualifying for services. There is a statewide waiting list of approximately 1,000 consumers as of June 30, 1999.
- The NMHCBS program shifted many consumers to personal care service (more cost effective) from home health aid service based on newly developed criteria. Although this enabled the program to serve more consumers, it is believed that the program needs an infusion of funds as it has maximized cost efficiencies.
- Continued growth in both programs means continued and increasing demands on the professional and paraprofessional work force which is already strained.
- Innovative strategies are needed to continue to sustain consumers in their own homes.
- Nationally, there is a concerted effort by the disability community for input in their care. This is called "consumer directed care" or "person centered planning". Numerous articles are also articulating the notion that the "baby boomers " will also want more involvement in how their current and future needs are met.[16]
- Alternative residential settings must continue to expand. Consumers who can not maintain themselves in their home, but are not ready for a nursing facility, need alternative choices.
- Consumers will continue to need assistance with coordination of care/services via some type of case management or care coordination (case management is described in Appendix B).

Continued on next page

[15] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

[16] Accountability Action – Volume 4: Issues 1 and 2 (fall 1999 / winter 2000). "The Need is Real, The Time is Right," published by the Foundation for Accountability, Portland Oregon.

Chapter 2: What are the Trends in Enrollment?, Continued

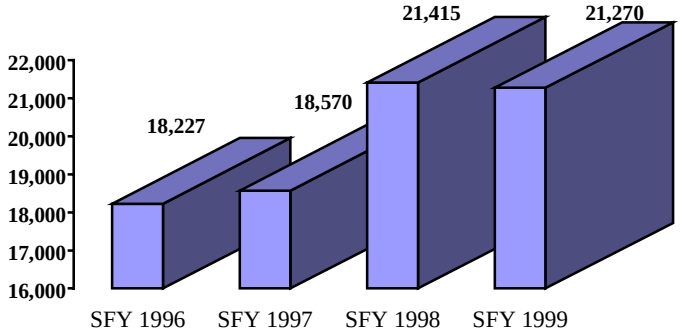
NMHCBS

The NMHCBS program has grown by approximately 14% (18,227 to 21,168) in the last four years. However, the program did see a 1% decline in enrollment from 1998 to 1999. This slight decrease is attributable to:

- Consumers transitioning to ALTCS;
- Increased adherence by case managers to the functional eligibility criteria;
- Decreased applications in the SSI population since the $70.00 payments for the housekeeping are no longer available;
- Fixed cost, meaning no additional funds were available to accommodate demand; and
- Potential consumers on the waiting list were not served.

Services

NMHCBS offers seven in-home services; adult day health care (ADHC), home delivered meals (HDM), home health aid (HHA), home nursing (NUR), housekeeping (HSK), personal care (PC), and respite care (RC). The graphs below illustrate the total number of unduplicated (counted only once) clients. Consumers may however, receive several services at one time (e.g., personal care, meals, and housekeeping).



Note: *This includes individuals receiving Adult Day Health, Home Delivered Meals, Home Health Aid, Housekeeping, Personal Care, Respite Care, Home Nursing, and Case Management. Reflects an unduplicated count.*

Enrollment Growth

The table below illustrates the percentage of growth in enrollment from state fiscal year 1996 to state fiscal year 1999.

NMHCBS Service	% of Growth SFY 1996 to 1999	Explanation for Double-Digit Changes
Home Health Aid	-26% (Decrease)	Establishment of medical needs criteria for service; if it is purely functional, the consumer is given a personal care service.
Home Nursing	-10% (Decrease)	Establishment of medical need criteria for service
Adult Day Health	1%	N/A
Housekeeping	6%	N/A
Home Delivered Meals*	22%	Native Americans are reporting consumer counts*
Personal Care	26%	Consumers began using personal care service if the assistance needs were functional in nature only and had no medical component
Respite Care**	73%	Increase in funding and better accounting of consumer use

*Duplicate counts – numbers may decrease for SFY 2000 with an unduplicated count.
**1996 – Pilot Project Region One. 1997 – Substantive additional state funding.

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NMHCBS Services SFY99

The table below illustrates the number of persons utilizing NMHCBS by service and by county.

N M H C B S (OWN HOME)

COUNTIES	HHA	PC	HOME NURSING	HSK	RESPITE	HDM	ADHC	Unduplicated Count
Apache	0	1	77	64	88	2701	0	2846
Cochise	19	119	102	390	33	525	0	877
Coconino	45	0	69	175	23	350	0	531
Gila	50	0	33	131	30	221	0	401
Graham	0	46	35	136	16	143	0	261
Greenlee	0	26	58	96	0	67	0	157
LaPaz	0	25	0	93	3	114	0	178
Maricopa	633	691	147	2665	113	3228	180	6585
Mohave	77	43	64	286	56	1069	0	1377
Navajo	58	28	91	188	23	486	0	691
Pima	2	698	141	1401	84	1358	163	3667
Pinal	131	72	254	218	14	428	0	1093
Santa Cruz	95	6	134	108	8	94	0	263
Yavapai	305	0	325	203	18	1175	27	1513
Yuma	38	47	13	235	26	467	31	930
Totals	**1,453**	**1,802**	**1,543**	**6,389**	**535**	**12,426**	**401**	**21,270**

Key: HHA =Home Health Aid, PC = Personal Care, HSK = Housekeeping, HDM = Home Delivered Meals, ADHC = Adult Day Health Care.

ALTCS / HCBS

Although nursing facility enrollment has increased since 1997 (9,166 to 9,460), as the percentage of the total population, it has decrease by 4%(54% to 50%). Conversely, the HCBS percent of the total population has increase by 4%.

ALTCS does not have enrollment figures by specific in-home services. However, AHCCCS has placement information that assists the program with trending consumer choices. The ALTCS HCBS program offers consumers the choice of living in their own home or in a community setting. The community settings are:

- Adult foster care (AFC);
- Assisted living home or center/unit; or
- Behavioral health (BH) setting.

The HCBS population is divided into "own home" and "alternative."

- The own home population has grown since 1997 (5,480 - 6,599). As a percentage of the total HCBS population it has decreased by 4% (88% - 84%).
- The alternative residential population has grown from 942 members in 1997 to 1,226 members in 1999. As a percentage of the HCBS population, it has grown 4% (12% - 16%).

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Alternatives

As a percentage of alternative residential settings, the following applies:

- AFCs, having the greatest number of consumers, has decreased from 73% in 1997 to 50% in 1999;
- Assisted living centers have increased from 11% in 1997 to 24% in 1999;
- Assisted living homes have increased from 16% in 1997 to 23% in 1999; and
- Behavioral health homes have increased from 4% in 1997 to 6% in 1999.

Note: *See Appendix A for definitions.*

ALTCS In Home Services & Settings

The chart below illustrates the number of persons receiving services in their own home or in alternative settings in the community by service/setting and county in FFY1999.

County FFY99	Home and Community-Based Services (HCBS)					
	*Own Home	AFC	ALC	Behavioral Hlth.	ALH	Total
Apache	40	-	-	-	4	44
Cochise	240	1	-	-	9	250
Coconino	58	-	-	1	5	64
Gila	61	-	-	-	3	64
Graham	35	-	-	-	4	39
Greenlee	5	-	-	-	-	5
La Paz	26	1		-	-	27
Maricopa	3,485	397	176	49	60	4,167
Mohave	176	28	32	-	14	250
Navajo	112	-	-	-	20	132
Pima	948	126	67	23	92	1,256
Pinal	311	4	8	3	28	354
Santa Cruz	108	-	-	-	8	116
Yavapai	338	19		1	14	372
Yuma	128	-	11	-	16	155
Totals	**6,071**	**576**	**294**	**77**	**277**	**7,295**

*Own Home means any combination of adult day health, home delivered meals, home health nursing and/or aid, housekeeping, personal care, and/or respite care delivered in the consumer's home.

Key: AFC= Adult Care Home; ALC= Residential Living Center; ALH= Assisted Living Home; Behavioral Health = Special TBI homes, licensed level II homes, and level I homes.

Total HCBS for all Counties: 7,295
Total Alternative Residential: 1,224 (18%)

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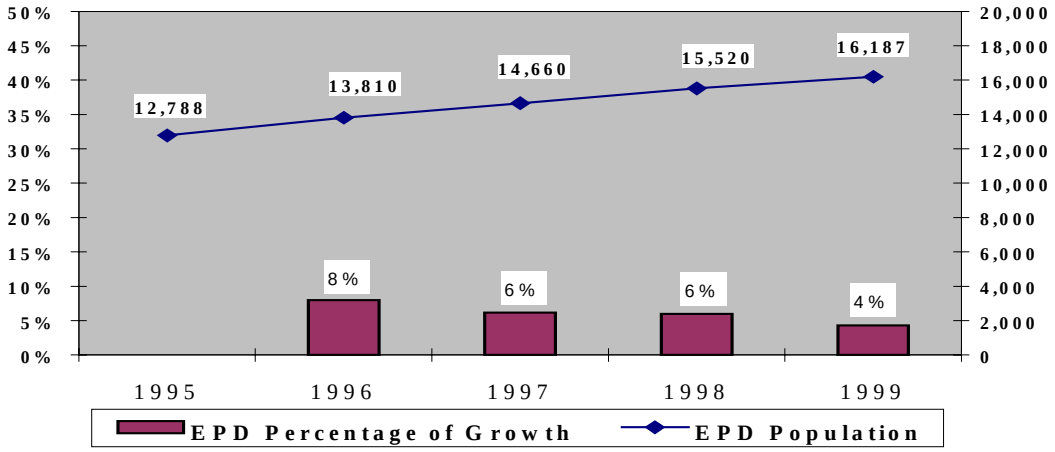
ALTCS / EPD Enrollment

The following graph includes statistics on Elderly and Physically Disabled enrollments from 1995 - 1999.

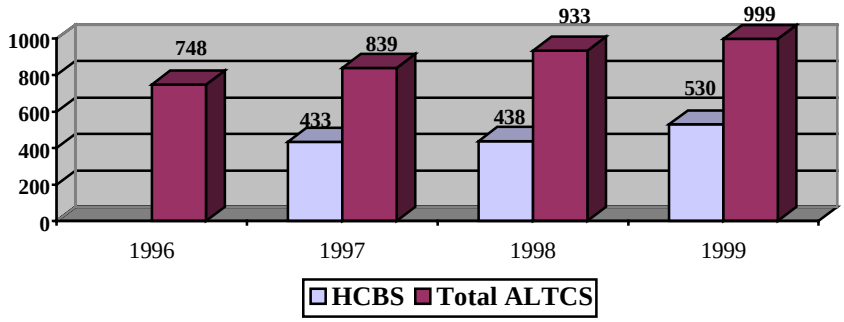


Note: Excludes "On Reservation " Native Americans.

ALTCS / HCBS Native American EPD Enrollment

The ALTCS Native American population resides either "On Reservation" or "Off Reservation." Most "off reservation" Native Americans (urban) are enrolled with the Program Contractor who provides services for that county. "On Reservation" Native Americans are either case managed by their tribe or by the *Native American Community Health Center (NACHC). There has been a steady increase in both total ALTCS population and in the number of consumers in HCBS. The increase in HCBS is attributable to the efforts of both the Inter-Tribal Council of Arizona (ITCA) and the Navajo Nation.

ITCA received a five-year grant in 1998 to target and assist tribes in their efforts to build HCBS networks. They have also been diligent in developing outreach programs with regard to the ALTCS program. The Navajo Nation has also made strides in developing an independent provider network as well as collaboratively working with their service units to increase workers for the ALTCS HCBS consumers who live on reservation. The chart below shows statistics on ALTCS Native American population growth. There has been a 25% increase in population during the last four years and 18% growth in HCBS during the last three years.



Note: 1996 HCBS statistics unavailable.
*Native American Community Health Center (NACHC) represents all other tribes not contracted with AHCCCS.

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ALTCS In-Home Services / Settings-Native American

The chart below illustrates the number of persons receiving services in their own home or in alternative residential settings in the community by tribe and services/settings in FFY1999.

Tribe	Home and Community-Based Services (HCBS)					
	*Own Home	AFC	ALC	Behavioral Hlth.	ALH	Total HCBS
Gila River	14	-	-	-	1	15
NACHC*	57	-	-	-	-	57
Navajo	323	-	-	-	-	323
Pascua Yaqui	16	-	-	-	-	16
San Carlos	5	-	-	-	-	5
Tohono O' Odham	69	-	-	-	-	69
White Mountain	44	-	-	1	-	45
Totals	**528**	**-**	**-**	**1**	**1**	**530**

*Own Home means any combination of adult day health, home delivered meals, home health nursing and/or aid, housekeeping, personal care, and/or respite care delivered in the consumer's home.

Key: AFC= Adult Care Home; ALC= Residential Living Center; ALH= Assisted Living Home; Behavioral Health = Special TBI homes, licensed level II homes, and level I homes.

Total HCBS for all Tribes: 530
Total Alternative Residential: 2

Chapter 3: Where Does Program Funding Come From?

Introduction

As the individuals with disabilities and the aging populations grow in Arizona, the demand for Non-Medical Home and Community Based Services (NMHCBS) and medically necessary long-term care (LTC) services (nursing facility and HCBS) will increase. These services are primarily funded by Medicaid (Title XIX), through the Arizona Health Care Cost Containment System (AHCCCS), and state services through the Arizona Department of Economic Security (ADES) (Title III/XX, and community funds). To further clarify the funding for both programs, more detailed information is provided in this chapter.

Fast Facts

- The majority of NMHCBS program dollars for home care (RN, HHA, PC, HSK, and ADHC) is from state appropriations (74%). This program is not an entitlement, but an appropriation. The state appropriation has remained at $8 million annually since 1994.
- The majority of ALTCS program dollars are from federal appropriations (65%). This program is an entitlement.
- Nationally, less than one half of those over 65 have set aside an adequate amount of money to take them all the way through retirement.[17]
- "Nationally, younger boomers (32 to 40 years old) have experienced significant declines in their real income levels. Close to 15% of all baby boomers lack a high school diploma."[18]

Implications

The NMHCBS program is not an entitlement. Therefore, funding or increases in funding may vary given other governmental priorities. This may have an impact on services to consumers who depend on this program for assistance. For example, the waiting list increased 40% in SFY 1999, growing from 800 to 1,122 consumers.

The ALTCS program is an entitlement based on financial, functional and medical criteria. As an entitlement program, ALTCS has a better ability, financially, to meet consumer needs.

The increase in the future population over age 65 and the fact that they may not have enough money to take care of their needs may put a significant stress on the amount of appropriated dollars that will be required to maintain consumers at a maximum level of independence.

NMHCBS

Federal, state, and local funding are combined to support the NMHCBS System. The funding sources include the following:

- Federal Funds:
  - Older Americans Act (PL 89-73) (OAA, Title III and Title VII), and
  - Social Services Block Grant (SSBG);
- State Appropriated Funds; and
- Locally generated sources including client contributions, city funds, county United Way funds, and local foundations.

Continued on next page

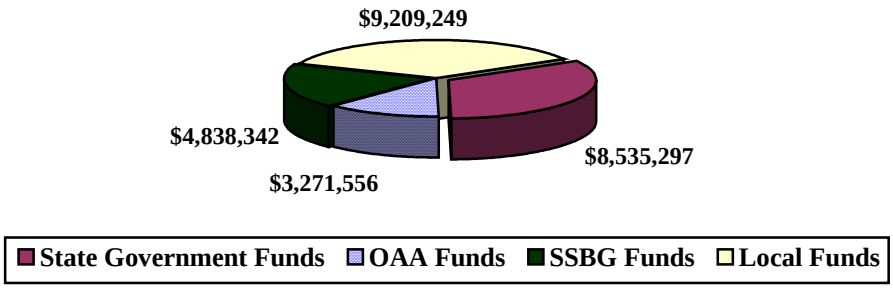
[17] 72nd Arizona Town Hall and University of Arizona (1998). Tucson, Arizona.

[18] Aging Initiative: Project 2030 (January, 1999). "Workforce and Economic Vitality Issue Paper," p. 6, St. Paul, Minnesota.

NMHCBS, Continued

The total service funds for NMHCBS for SFY 1999, which were expended, is $25,854,445. The breakout is indicated below.

- Home Care funding includes RN, HHA, PC, HSK, ADHC, and CM. Total funding for this area was 74% state and 26% federal funds.
- Home Delivered Meals are primarily federally funded.
- County, community, and consumer contributions are allocated to the home care and meals programs. These additional funds enable more people to be served.



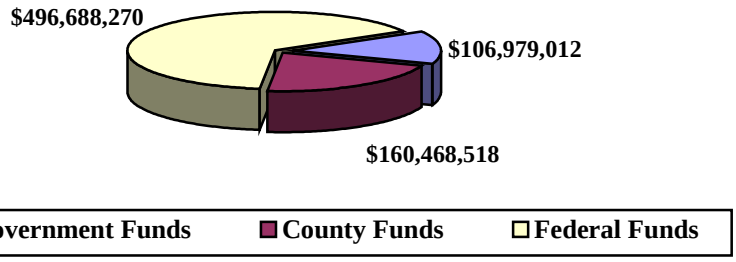
Total Funds for SFY 1999: $25,854,444

ALTCS / HCBS

The ALTCS program (EPD and DD) is funded by three sources:

- Federal funds (Title XIX) = 65%,
- County funds = 21%, and
- State funds = 14%.

ALTCS Sources of Funds for FFY 1999:



Total Funds for FFY1999: $764,135,800

Services include medical, behavioral, nursing facility and HCBS. The total ALTCS funds for FFY 1999 were $764,135,800 (includes Title XIX DDD population). The ALTCS budget is approximately 40% of the entire AHCCCS budget. Sixty-seven percent of the ALTCS population are Elderly or Physically Disabled (EPD). Of those, 43% resided in the community.

Note: *EPD only budget is approximately $560 million.*

Chapter 4: How is the Money Spent?

Introduction

In 1989, the median income in Arizona for a single male 65 years of age or older was $13,210 versus single women who were at $10,320. Also of note is that Arizona Native Americans account for 17% of the Native American population 65 years of age or older in the United States.[19] These two facts imply that, for a fair share of our population, the ability to purchase needed services will be limited.

As the baby boomer generation continues to age, there is increasingly more demand for HCBS services, thereby producing an increase in spending. Chapter four will describe how the money is spent and on what type of services. It will also demonstrate that HCBS services and settings, in the ALTCS program, are cost efficient and respond to consumer choice.

Fast Facts

NMHCBS expenditures are reported by State Fiscal Year (7/1 to 6/30). Expenditures have grown 15% from 1996 to 1999. The biggest increases are in personal care and respite care, which correlates with the shift from home health aid to personal care and the increase in demand and funding for respite care. Nationally, "respite care is the most prevalent service provided by states for family caregivers."[20]

ALTCS HCBS expenditures have grown by 40% from 1996 to 1999.

- The biggest increase is in the category called "other," which incorporates Adult Day Health Care (ADHC), Environmental Modification and Alternative Residential Settings. As ADHC and Environmental Modification expenditures have remained essentially the same for three years, the conclusion is that the addition of assisted living centers and homes is the key factor in the increase.
- There has been a shift from personal care (-18%) to attendant care (+32%) thereby accounting for the increase in expenditures for attendant care. Many consumers prefer attendant care as that person can take care of numerous needs including housekeeping (HSK) while the personal care worker is limited to a person' s care needs.
- The EPD population has continued to grow from 6% to 9% annually. During the same timeframe, HCBS growth has gone from 35% to 43%. The growth in capitation has remained almost constant from 1996 to 1999 because it is more cost effective to maintain consumers in their own home or alternative setting. Trends indicate the number of people living in the community will continue to increase.

Continued on next page

[19] 72nd Arizona Town Hall and University of Arizona (1998). "The Challenges and Opportunities of Arizona' s Growing Senior Population,"pp. 1-3, Tucson, Arizona

[20] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.

Fast Facts, Continued

The ALTCS Program as a whole somewhat mirrors the national trend for Medicaid.

- "Nationally, in 1993, poor elderly and non-elderly disabled represented 27% of the total Medicaid enrollees, but 59% of all Medicaid dollars. Impoverished adults and children, on the other hand, represented 73% of enrollees, but consumed only 27% of all Medicaid dollars."[21]
- Services for the ALTCS program include medical, behavioral, nursing facility, and HCBS. The total ALTCS funds for FFY 1999 were $764,135,800 (includes DDD population). The ALTCS budget is approximately 40% of the entire AHCCCS budget. The EPD only AHCCCS budget is approximately 30% of the entire AHCCCS budget. Sixty-seven percent of the ALTCS population are Elderly or Physically Disabled (EPD). Of those, 43% resided in the community in FFY 1999.

Implications

As the long-term care programs become a greater portion of our government' s budget, the state needs to understand the following:

- Baby boomers may request changes in the current service venue that may or may not impact expenditure.
- Both programs are researching strategies to continue to hire paraprofessionals to meet the consumer demand. This is especially important in the recruitment of attendant care providers.
- As the need for health and long-term care is growing, our resources will be increasingly stretched.

"The most significant is the fact that the baby bust generation (the generation following the baby boomers) constitutes a much smaller proportion of the population than the baby boomers. As a result there will be fewer working age adults to support the needs of a large elderly population through their economic productivity and tax revenues."[22]

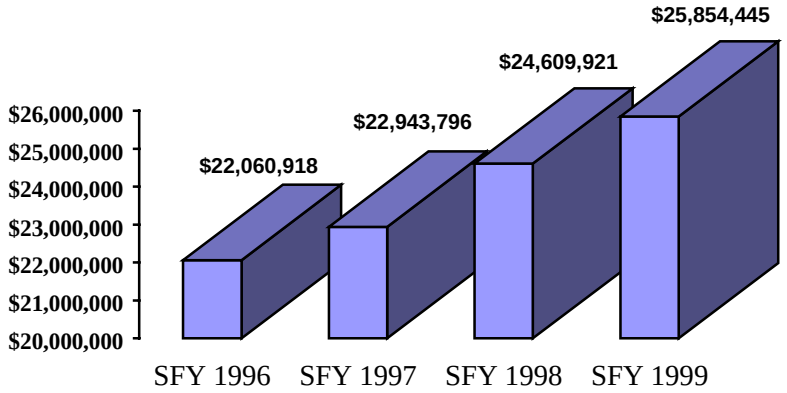
Continued on next page

[21] The Robert Wood Johnson Foundation (August, 1996). "Chronic Care in America: A 21st Century Challenge," p. 46, Princeton, New Jersey.
[22] Aging Initiative: Project 2030 (January, 1999). "Health and Long-Term Care Issue Paper," p. 2, St. Paul, Minnesota.

NMHCBS

NMHCBS has seen an increase in cost from approximately $22 million in SFY 1996 to $25 million in SFY 1999. Non-medical HCBS expenditures are reported on a state fiscal year (July 1 to June 30) schedule. Total expenditures for SFY 1999 are $25,854,445. This includes federal, state, county, and community contributions.

The graph below shows the totals for all of the non-medical expenditure years. Figures include case management with a range from $3.5 million to $4.4 million from SFY 1996 to SFY 1999.

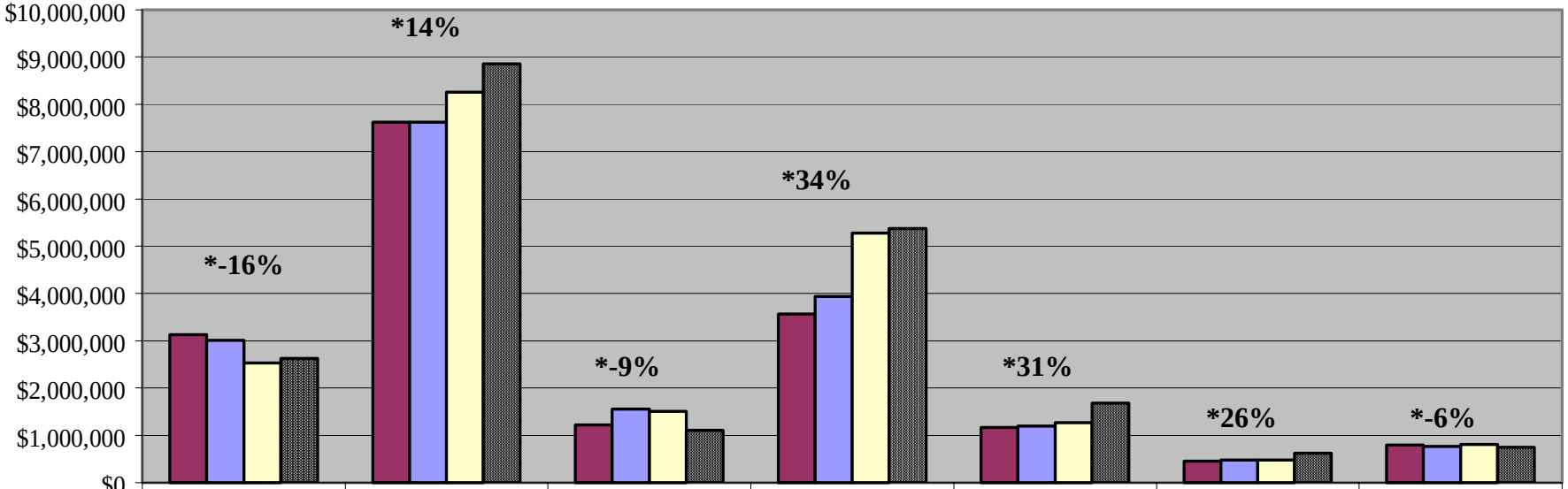


Increases and decreases in enrollment reflect the increases and decreases of expenditures for the NMHCBS program. The table below states the total increase and decrease in expenditure from 1996 to 1999. The chart on the following page demonstrates increases and decreases by year.

Service	% of Growth: SFY 1996 to SFY 1999
Adult Day Health	-16% (Decrease)
Home Health Aid	-9% (Decrease)
Home Nursing	-6% (Decrease)
Home Delivered Meals	14%
Respite Care	26%
Personal Care	31%
Housekeeping	34%

Continued on next page

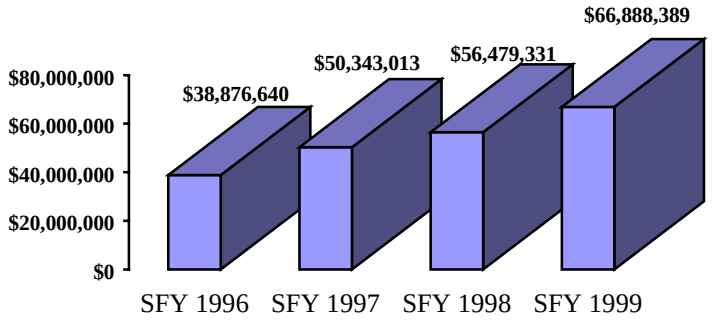
Non-Medical Home and Community Based Services (NMHCBS): Expenditures (State and Federal Funds)



	Adult Day Health	Home Delivered Meals	Home Health Aide	Housekeeping	Personal Care	Respite Care	Home Nursing
1996	$3,127,483	$7,621,071	$1,218,345	$3,565,129	$1,165,449	$456,598	$794,531
1997	$3,004,569	$7,627,404	$1,558,474	$3,936,874	$1,200,002	$477,736	$763,238
1998	$2,529,550	$8,254,681	$1,510,502	$5,277,400	$1,267,814	$479,268	$806,051
1999	$2,626,413	$8,849,598	$1,106,902	$5,376,389	$1,685,448	$620,857	$746,744

*Indicates growth percentage from 1996 through 1999

ALTCS / HCBS The ALTCS HCBS program (LTC services only) has experienced a 40% growth in expenditures in the last four years. The figures below represent expenditures for all services as reported by the Program Contractors.



ALTCS / HCBS The enrollment increases in the ALTCS HCBS program as well as the increases in the utilization of services are reflective of the increases of expenditure for the program. The table below states the total increase and decrease in expenditure from 1996 to 1999.

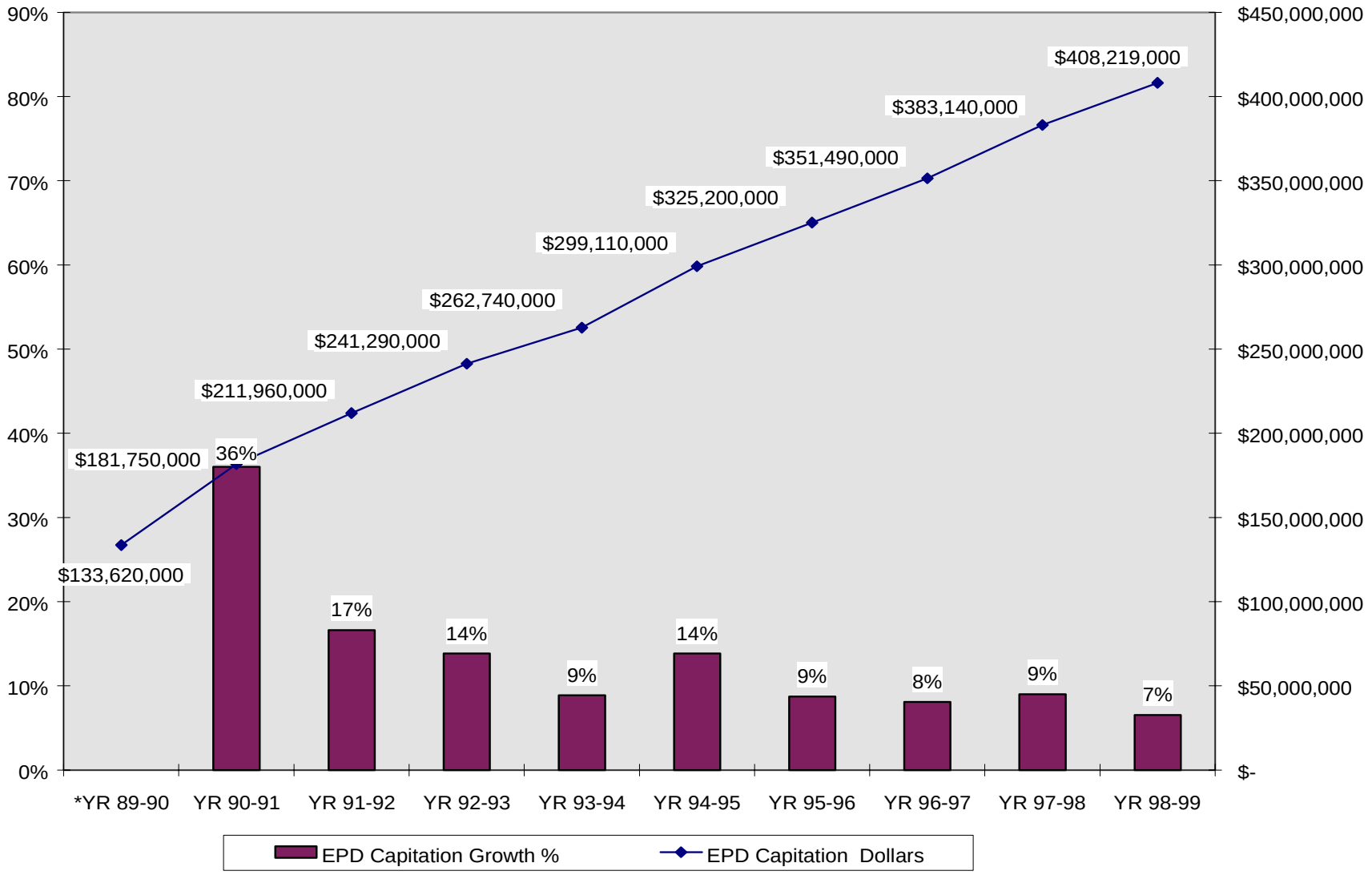
Service (Excludes Case Management)	% of Growth: FFY 1996 to SFY 1999
Home Health Services (RN & HHA)	5%
Attendant Care	32%
Home Delivered Meals	45%
Housekeeping	11%
Personal Care	18%
Other (Adult Day Health, Environmental Modification, Alternative Residential Settings)	87% (Attributable to Alternative Residential Settings)
Respite Care	58%

The chart on the following page demonstrates increases and decreases by year.

ALTCS / HCBS The final two graphs are particular to the ALTCS program as a capitated model.

- Referencing the graph on page 18, it demonstrates that during the past four years the amount paid by Program Contractors for nursing facility and HCBS services has had an average annual growth of 7% to 9%. This mirrors the EPD population growth**.**
- The final graph on page 19 demonstrates that the EPD population has continued to grow from 6% to 9% annually. During the same timeframe, HCBS growth has gone from 35% to 43%. The growth in capitation has remained almost constant from 1996 to 1999 because it is more cost effective to maintain consumers in their own home or alternative setting.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
ELDERLY AND PHYSICALLY DISABLED CAPITATION DOLLARS PAID ANNUALLY



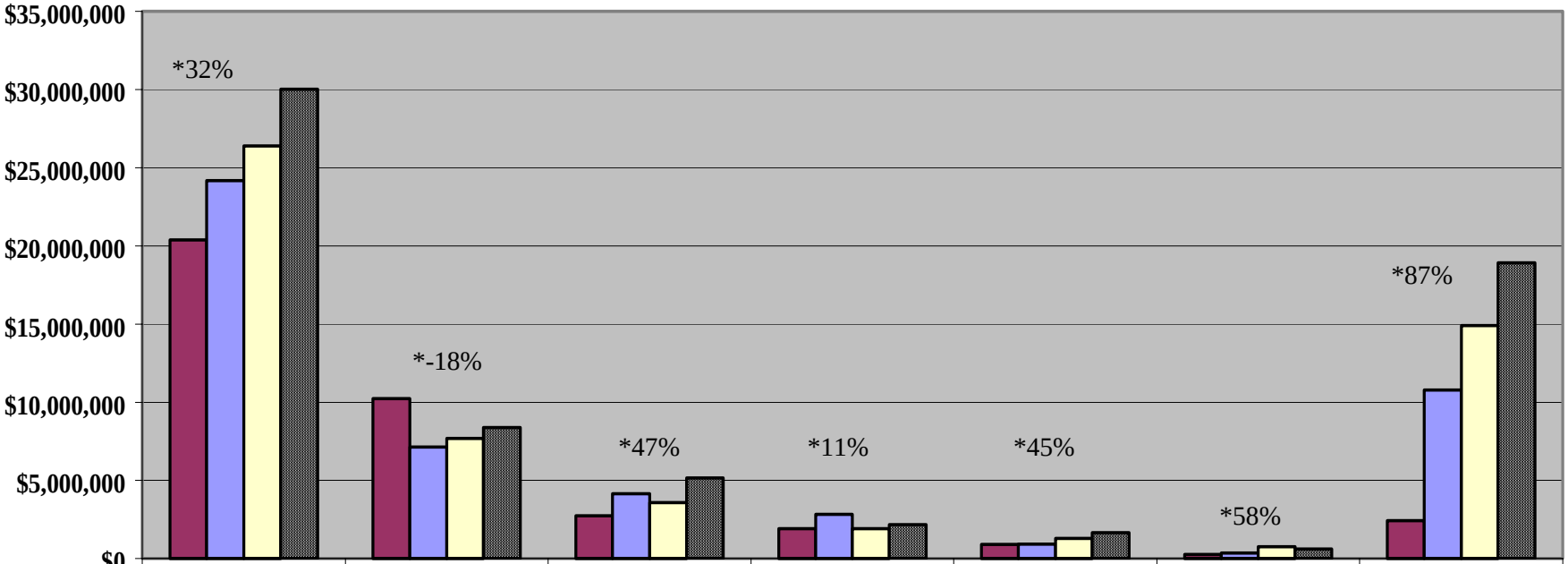
*Program began 1/1/89

Excludes: Ventilator Dependents and Native Americans

ALTCS HCBS PROGRAM

State-Wide Expenditures by Service

(As Reported by Program Contractors)



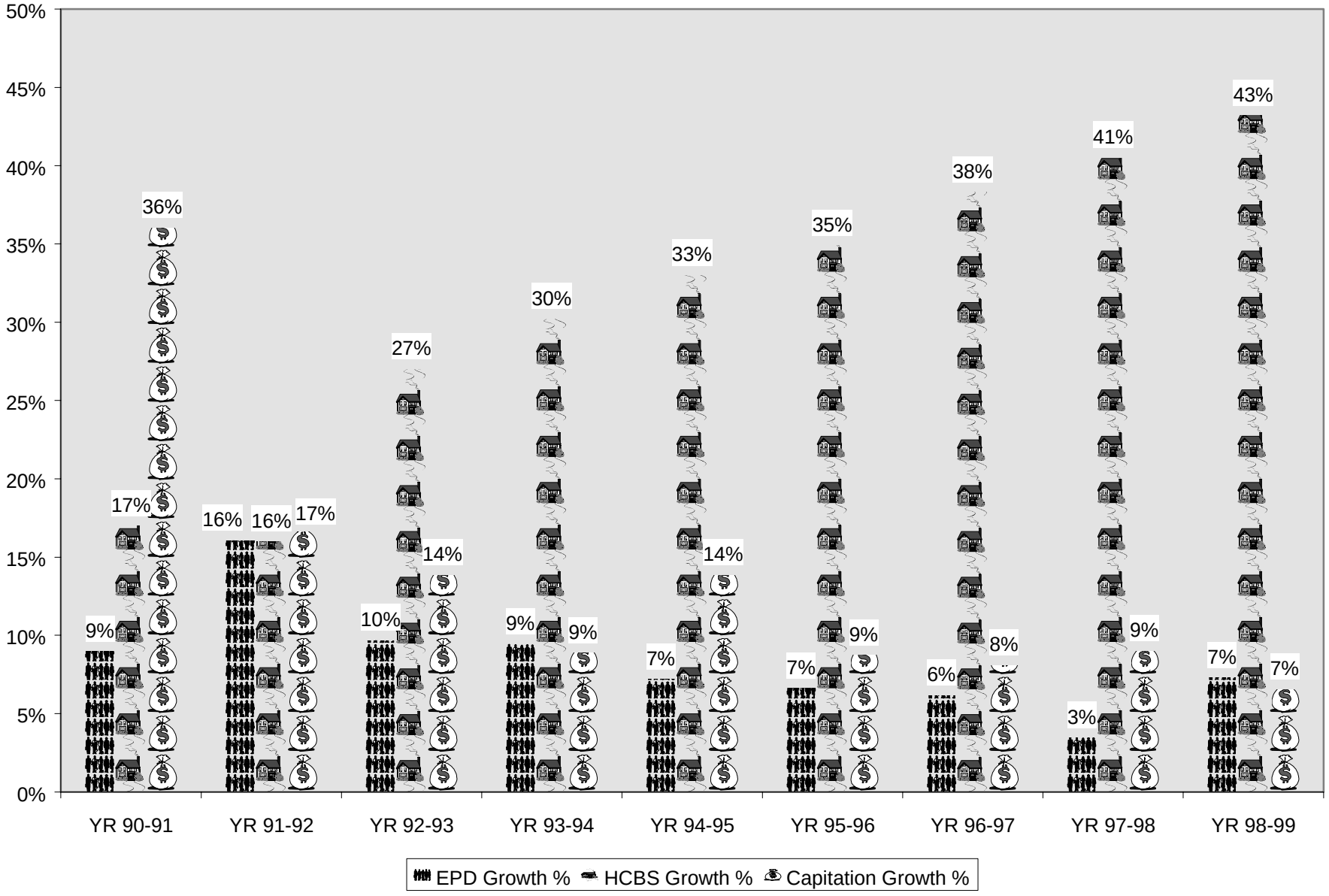
	Attendant Care	Personal Care	Home Health	Homemaker	Home Del. Meals	Respite	Other
1996	$20,377,039	$10,224,461	$2,730,558	$1,909,203	$907,148	$258,412	$2,420,818
1997	$24,168,369	$7,133,378	$4,153,775	$2,837,652	$923,377	$362,509	$10,763,953
1998	$26,389,961	$7,685,142	$3,570,080	$1,908,316	$1,282,218	$754,429	$14,889,185
1999	$30,022,152	$8,373,212	$5,152,253	$2,162,113	$1,659,547	$614,431	$18,904,681

*Indicates growth percentage from 1996 through 1999

Note: *"Other" includes adult day health care, environmental modification, and alternative residential settings.*

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

ELDERLY AND PHYSICALLY DISABLED PERCENT OF GROWTH FOR HCBS PLACEMENT, ENROLLMENT, CAPTIATION DOLLARS



Appendix A: Definitions

Services

*Starred Items mean that both programs provide this service.

***Adult Day Health:** A program that provides planned care and supervision, recreation and socialization, personal living skills training, group meals, health monitoring and various preventive, therapeutic and restorative health care services.

Arizona Long-Term Care System (ALTCS): ALTCS is a program under AHCCCS that delivers long-term, acute, behavioral health, and case management services to members, as authorized by A.R.S. § 36-29321. Long-term Care services include both nursing facilities and HCBS.

Attendant Care: A service provided by a trained attendant for members who reside in their own homes and which may include homemaker services, personal care, coordination of services, general supervision and assistance, companionship, socialization and skills development. **(ALTCS/HCBS only)**

Case Management (ALTCS/HCBS): The process through which appropriate and cost effective medical, medically-related social services, and behavioral health services are identified, planned, obtained, and monitored for individuals eligible for ALTCS services (A.A.C. R9-28-510). The process integrates the ALTCS member's and the case manager's review of the member's strengths and needs resulting in agreed upon appropriate and cost effective acute and long term care services.

Case management (NMHCBS): The assessment and development of an individualized service plan through which the eligibility of an individual is determined, appropriate services or benefits are identified, planned, reported, monitored or terminated, and follow-up is provided if and when appropriate (A.R.S. § 46-191.3).

***Chore/Pest Control:** A service that provides building specifications or items which allow members to function as independently as possible in their own homes.

***Emergency Alert System:** A service that provides monitoring devices/systems for members who are unable to access assistance in an emergency and/or live alone.

Environmental Modification: A service that provides building specification or items which allow members to function as independently as possible in their own homes. **(ALTCS only)**

***Home Delivered Meals:** A service that provides a nutritious meal containing at least one-third of the federal recommended daily allowance for the member, delivered to the member's own home.

Home Health Aid (NMHCBS Definition): This service provides intermittent health maintenance, continued treatments or monitoring of a health condition, and supportive care for daily living activities at the individual's place of residence.

Home Health Services: (ALTCS Definition): Includes Home Health Aid and Home Nursing (Intermittent or Continuous). Part-time or intermittent care for members who do not require hospital care; service is provided under direction of a physician to prevent re-hospitalization or institutionalization; may include nursing, therapies, supplies and home health aid services.

Continued on next page

Services, Continued

***Homemaker:** A service that provides assistance in the performance of routine household activities such as shopping, cooking and running errands.

Home Nursing (NMHCBS Description): This service provides intermittent skilled nursing services in the individual' s place of residences. Skilled nursing services may include health maintenance, continued treatments, or supervision of a health condition.

Non-Medical Home and Community Based Services (NMHCBS): A comprehensive, case managed system of care provided to a functionally disabled individual in the individual' s home or community that supports the role of family and caregivers as part of the service plan. The service plan may include personal care, housekeeping, chore services, adult day health care, respite, and home delivered meals, as well as health care services and other related health and social services that are a necessary, but subordinate, part of the service plan (A.R.S. § 46-191.7).

***Personal Care:** A service that provides assistance with personal physical needs such as washing hair, bathing and dressing.

Respite Care (ALTCS Description): Includes groups, in-home and continuous respite care. A service that provides short-term care and supervision to relieve primary caregivers. It is available for up to 24-hours per day and limited to 720 hours per year. Group respite is similar to Adult Day Health and is provided as a substitute when Adult Day Health services are not available.

Respite Care (NMHCBS Description): This service provides short-term care and supervision to relieve primary caregivers or clients. May be referred to be available on a 24-hour basis.

Transportation: A service that provides non-emergency transportation to medical, social or related activities.

Settings Limited to ALTCS

Adult Foster Care: An ALTCS HCBS approved alternative residential setting that provides room, board, supervision and coordination of necessary services within a family type environment for up to four adult residents.

Assisted Living Home (formerly known as "Adult Care Home"): An ALTCS approved alternative residential setting that provides resident rooms to ten or fewer residents. For ALTCS approval, the home must be certified to provide personal care.

Assisted Living Centers- Units Only (formerly known as "Supportive Residential Living Centers"): An ALTCS approved alternative residential setting that provides a private apartment, unless otherwise requested by a resident, that includes a living and sleeping space, kitchen area, private bathroom and storage area.

Behavioral Health Level II: A behavioral health service agency licensed by ADHS to provide a structured residential setting with 24-hour supervision and counseling or other therapeutic activities for individuals who do not require the intensity of treatment services or on-site medical services found in a Level I behavioral health facility.

Appendix B: HCBS Programs: Similarities and Differences

NMHCBS

The Aging and Adult Administration (AA) within the Arizona Department of Economic Security (ADES) is responsible for delivery of Non-Medical Home and Community Based Services (NMHCBS) for individuals 60 years of age or older or disabled who meet the eligibility requirements. The program receives state, federal, and local funding. There are eight Area Agencies on Aging (AAA) and one prime sponsor (non-AAA entity) that serve individuals in Arizona. AAAs utilize a case management system to determine need and authorize services. The AAAs are responsible for contracting with providers for the direct provision of services.

The program provides in-home, respite, and adult day health care services. On reservations, consumers receive home delivered meals and respite care via the AAA. All consumers live in there own home. Other in-home services provided to reservations are through federal funds that are given directly to the tribes. Services are limited by available federal and state funding.

ALTCS

The Arizona Health Care Cost Containment System (AHCCCS), Arizona Long-Term Care System (ALTCS) is funded by federal, state, and county monies. ALTCS serves the elderly, physically disabled, and developmentally disabled determined to be at an institutional level of care and financially eligible. Acute (medical), institutional, case management, home and community based services, and behavioral health services are all covered services under ALTCS. Members are enrolled with AHCCCS contracted managed care organizations (program contractors). There are eight program contractors including the Arizona Department of Economic Security / Division of Developmental Disabilities (ADES/DDD). The eight program contractors provide case management and services in designated geographic areas. ADES/DDD provides case management and contracts with individual providers to render care to members statewide. "On-Reservation" EPD tribal members receive case management. The remainder of the service package is on a fee-for-service basis. During FFY 1999, 67% of the ALTCS population served were EPD. Of that number 43% lived in the community receiving in-home services or lived in alternative residential settings.

Case Management

For both programs, case management is a central cog and key service in the coordination of hands-on services. In the NMHCBS program, where funding is limited, the case manager plays a critical role in assessing finances and assisting the consumer, when possible, in the private purchase of a service, or perhaps, community scholarship funds for the service. As a Medicaid program, ALTCS has prescribed financial, functional, and medical criteria. Eligibility is determined by AHCCCS prior to the consumer receiving a case manager. The ALTCS program is required to provide for the needs of all members in the community up to the cost that would be spent if the consumer were in the facility.

The case manager will make every effort to foster a person-centered approach and respect maximum member/family self-determination while promoting the values of dignity, independence, self-determination, individuality, privacy, and choice. Case management begins with respect for the member' s preferences, interests, needs, culture, language, and belief system.

Continued on next page

Appendix B: HCBS Programs: Similarities and Differences , Continued

Case Management, Continued

The involvement of the member in strengths and needs identification and in decision making is a basic tenet of case management practice. Care plan development is a shared responsibility with the member/family/significant others input seen as key to the success of the plan. The member/family/significant others are partners with the case managers in the development of the plan with the case manager in a facilitating mode.

Case managers are expected to use a holistic approach regarding the member assessment and needs, taking into account not only covered services but also other needed community resources as applicable. Case managers are expected to:

- Provide adequate information and teaching to assist the member/family in making informed decisions and choices;
- Provide a continuum of service options that support the expectations and agreement established through the care plan process;
- Integrate services available throughout the community;
- Advocate for the member, family or significant other as the need occurs;
- Allow the member, family, or significant other to identify their role in interacting with the service system;
- Provide members with flexible and creative service delivery options;
- Provide necessary information to providers about any changes in consumer's functional level to assist the provider in planning, delivering, and monitoring services; and
- Provide coordination across all facets of the service system in order to maximize the efficient use of resources and minimize any negative impact to the consumer.

Comparisons

Categories	NMHCBS	ALTCS HCBS
Eligibility	Meets functional/medical criteria: either 60+ or physically disabled	Meets financial, functional, and medical criteria
Funding Availability	Limited to federal and state allocations and community contributions– Not an entitlement	Medicaid funded program (federal, state, and county) - Entitlement based on eligibility
Case Management	No prescribed ratio of case manager to consumer. Caseload is usually a minimum of 100+ per case manager. Visits at 3 to 6 month intervals with SPP direct pay and wait list members with alternative visit intervals.	Caseloads have prescribed ratios. HCBS 1 to 48 with three month interval visits and SNF = 1:120 with 6 month intervals.
Services		
Acute Care	No	Yes
Behavioral Health Care	No	Yes
Adult Day Health Care	Yes	Yes
Attendant Care	No	Yes
Home Health Aid	Yes	Yes
Home Nursing	Yes/Limited	Yes/Extensive
Housekeeping/Pest Control	Yes	Yes
Home Delivered Meals	Yes	Yes
Personal Care	Yes	Yes
Respite Care	Yes	Yes
Environment Modification	No	Yes
Alternative Res. Settings	No	Yes
Waiting list for services	Yes (1,122), as of June 30, 1999	No

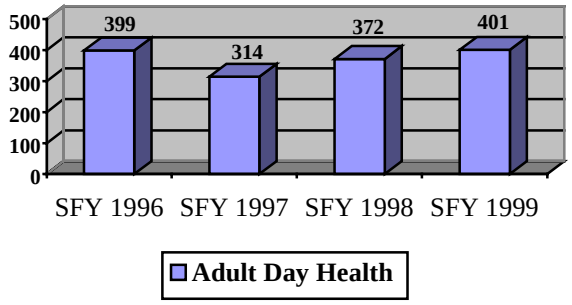
Appendix C: NMHCBS Enrollment Detail

Introduction

The following series of graphs demonstrates changes in the number of consumers who utilized the individual NMHCBS services over time.

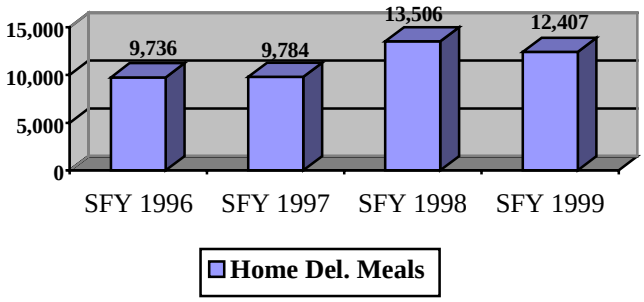
Adult Day Health (ADH)

The number of individuals utilizing ADH services has remained relatively consistent over this four your period of time.



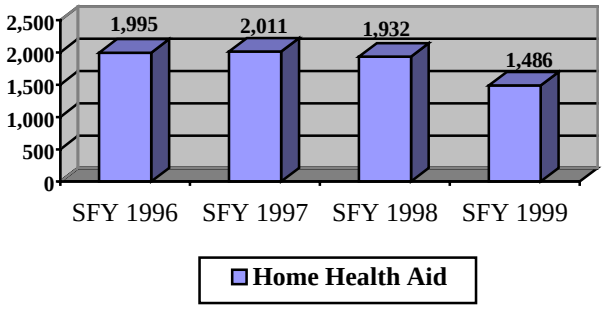
Home Delivered Meals (HDM)

The number of individuals utilizing HDM services has increased 8%. However, from 1998 to 1999, HDM services declined 1%.



Home Health Aid (HHA)

The number of individuals utilizing HHA services has declined by 26% from 1996 to 1999.



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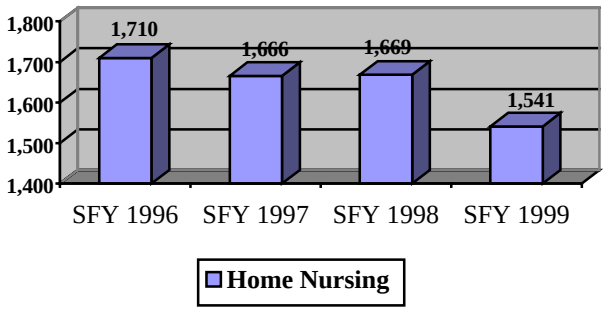
Appendix C: NMHCBS Enrollment Detail, Continued

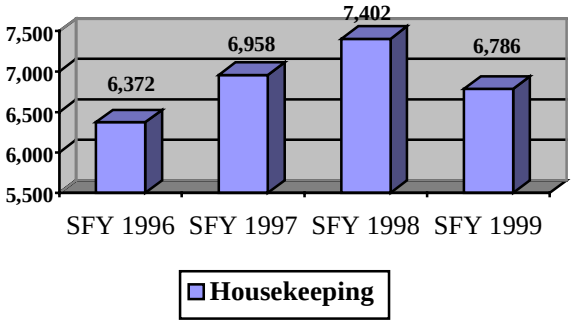
Home Nursing (NUR)

The number of individuals utilizing NUR services has declined by 26% from 1996 to 1999.



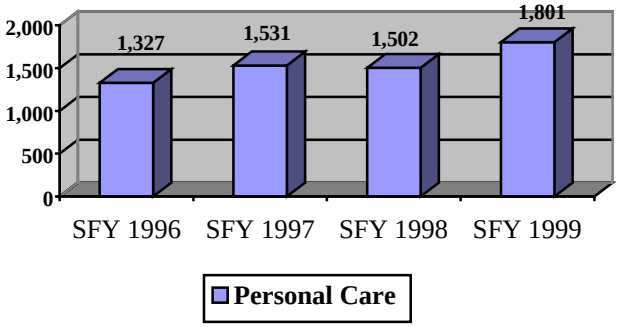
Housekeeping (HSK)

The number of individuals utilizing HSK services has increased 6%. However, there was an 8% decline of HSK services from 1998 to 1999.



Personal Care (PC)

The number of individuals utilizing PC services has increased 26%. However, from 1998 to 1999, PC services declined 8%.



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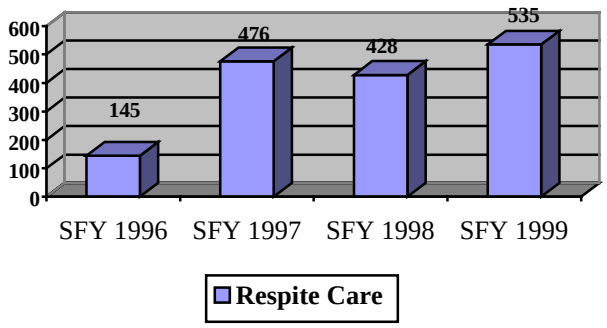
Appendix C: NMHCBS Enrollment Detail, Continued

Respite Care (RC)

The number of individuals receiving RC services has increased by 73%.



Appendix D: Copies of the Report

Availability

This report can be obtained through following options:

1. Viewing the Arizona Health Care Cost Containment System (AHCCCS) website: http:\\www.ahcccs.state.az.us;

2. Viewing the Arizona Department of Economic Security (ADES) website: http:\\www.de.state.az.us;

3. Writing to:
   Claire Sinay, Federal/State Policy Manager
   Office of Policy Analysis and Coordination
   801 East Jefferson Street, MD 4200
   Phoenix, Arizona 85034
   Fax Number: (602) 256-6756
   cxsinay@ahcccs.state.az.us; or

4. Calling:
   Melissa Brickey, AHCCCS/Administrative Assistant, at (602) 417-4146.

Appendix E: Acknowledgements

Taskforce Members

Below is a list of all the taskforce members and their organizations.

Name	Organization
Bercaw, Sharon	AHCCCS
Blanco, Henry	Aging and Adult Administration
Dean, Gwen	Arizona Bridge to Independent Living
Duncan, Gerry	Maricopa Managed Care System
Engan, Janet	Western Arizona Council of Governments
Fields, Karen	Pima Health Systems
Grabel, Stew	Pima Council on Aging
Guerrero, Olivia	Pinal/Gila Council for Senior Citizens
Heard, Kathleen	SouthEastern AZ Government Organization
Lupe Solis	Governor' s Council on Aging
Mercado, Jose	Aging & Adult Administration
Park, Carol	Cochise Health Systems
Schafer, Alan	AHCCCS
Skinner, Linda	AHCCCS
Stanley-Robb, Donna	Pinal County Long Term Care
Stewart, Laraine	Area Agency on Aging, Region One
Tomlinson, Cheri	AHCCCS
Wauneka, Theron A.	Inter-Tribal Council of Arizona, Incorporated